California Medi-Cal Dental Program

Denti-Cal Bulletin

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MEDI-CAL DENTAL PATIENT REFERRAL SERVICE

Medi-Cal Dental providers can take advantage of a free referral service for accepting Medi-Cal dental patients. This referral service can be an excellent resource for enrolled Denti-Cal providers to build, maintain or increase their patient base while making available the highest level of dental service for the state's medically needy.

If you are a provider interested in this service, or need to update the information currently on file, please fill out the attached Medi-Cal Dental Patient Referral Service Form and mail it to:

California Medi-Cal Dental Program
P.O. Box 15609
Sacramento, CA 95852-0609

Denti-Cal

California Medi-Cal Dental Program

Medi-Cal Dental Patient Referral Service

Dear Doctor:

The Medi-Cal Dental Program offers a patient referral service that serves the dental community statewide. Please consider our request to include your office on our referral list for Medi-Cal Dental patients.

Complete this form and return it to the Medi-Cal Dental Program in the enclosed envelope. Your participation in our patient referral service would be appreciated, however, this service is completely voluntary and does not affect your status as a Medi-Cal Dental provider.

Thank you for your participation in the Medi-Cal Dental Program. If you have any questions about the Medi-Cal Dental Patient Referral Service, please do not hesitate to call us toll-free (800) 423-0507.

Sincerely,
Provider Services
Medi-Cal Dental Program

☐ Yes I would like Medi-Cal Dental patients referred to my office. Please add my name to your referral list. I understand I may request removal of my name from this list at any time.

☐ No I do not want Medi-Cal Dental patients referred to my office. Please do not include my name on your referral list.

Provider Name: _____ Billing Provider ID: _____ Service Office #: _____

Business Name: _____

Fictitious Name: _____

Office Address: _____

Office Telephone: (____) _____ Is your office wheelchair accessible? ☐ Yes ☐ No

What other languages are spoken in your office? _____

List any dental specialties or services offered in your office (e.g., endodontic, periodontal, oral surgical procedures, general anesthesia, etc.): _____

What age group of children does your office see? ☐ 5 & under ☐ 6 – 12 ☐ 13 & older

Billing Provider Signature: _____ **Date:** _____